

We can retrieve your previous mammogram films for you prior to your appointment. Please print and complete this form, add your appointment date to the correct location where you are scheduled at Bon Secours, and then fax it to that location. We will do the rest!



Print Full Patient Name _____

Date of Birth _____

Daytime Phone # _____

I have had a previous mammogram at:

Address or Location

Approximate date that they were done at that location

St. Mary's Women's Imaging Center
 5875 Bremono Road – Suite 105
 Richmond, VA 23226
 Phone: (804) 287-7522 or 7501
 Fax: (804) 287-7504

Appt. Date _____

St. Francis Imaging Center
 8013 Midlothian Turnpike
 Richmond, VA 23235
 Phone: (804) 330-4600
 Fax: (804) 330-4647

Appt. Date _____

Richmond Community Hospital Mammography
 1500 N 28th Street
 Richmond, VA 23223
 Phone: (804) 225-1761
 Fax: (804) 225-1758

Appt. Date _____

Memorial Regional Medical Center Mammography
 8260 Atlee Road
 Mechanicsville, VA 23116
 Phone: (804) 764-6114
 Fax: (804) 764-6975

Appt. Date _____

Laburnum Diagnostic Imaging Center
 4630 S Laburnum Ave., Suite C
 Richmond, VA 23231
 Phone: (804) 226-4637
 Fax: (804) 222-7551

Appt. Date _____

Reynolds Crossing
 6605 W. Broad Street, Suite B, Ground Floor
 Richmond, VA 23230
 Phone: (804) 287-3500
 Fax: (804) 285-1405

Appt. Date _____

St. Francis Medical Center Mammography
 13710 St. Francis Blvd.
 Midlothian, VA 23114
 Phone: (804) 594-3189
 Fax: (804) 594-3187

Appt. Date _____

Authorization to Release Information

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the number above.
2. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility checked above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 (six) months.
3. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied according to hospital policy.

Signature of Patient or Legal Representative _____ Date _____



If signed by a legal representative, relationship to patient: _____

Signature of Witness _____ Date _____

Department Use Only

Processed by _____ Date _____

Information Received _____